2022

Employee Benefits Overview

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Medicare Part D Notice: If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a federal law gives you more choices about your prescription drug coverage. Please see the Annual Notices on the Court's website, **www.sbcourts.org/gi/hr/benefits.asp** for more details.

Benefits You Can Depend On

The Santa Barbara County Superior Court has a benefits program that provides you with the best coverage that is simple and comprehensive. We offer programs that protect your health, your money, your family and help you find balance between your concerns at work and at home. We also know the value of understanding your coverage so that you know how to get care, when you need it, at the lowest cost. With the tools and information in this booklet and related resources, we hope to help you be well today and work towards a healthy and secure future.

The Court understands that comparing benefit plans, features and costs can be complicated. This booklet provides information that will help simplify your decision making process. It is a summary of your benefits and does not provide a complete description of all benefit provisions. For more detailed information, please refer to your Evidence of Coverage documents (EOCs). The Evidence of Coverage documents determine how all benefits are paid and are available on the Court's benefits website, **www.sbcourts.org/gi/hr/benefits.asp**.

You can also contact CareCounsel to help you navigate and assist you with your health issues. Contact a CareCounsel representative at (888) 227-334 Monday – Friday from 6:30 am – 5:00 pm.

The benefits in this summary are effective:

January 1, 2022 - December 31, 2022

Open Enrollment Period: October 1 to October 31, 2021

What's New for 2022?

	There will be no benefit changes to the Blue Shield EPO or HDHP medical plan offerings for the 2022 plan year. However, premiums for the medical plans will have a 2% premium decrease!
	Introducing two new prescription programs through Express Scripts: • SaveOnSp a specialty drug program that can lower your costs to $0. • Safeguard Rx a program to help reduce prescription costs for Inflammatory Conditions Prescriptions for the EPO and HDHP will be moved to the following tiered system: • Tier 1 Drugs (Generic) • Tier 2 Drugs (Preferred Brands) • Tier 3 Drugs (Non Preferred Brands) • Tier 4 Drugs (Specialty Drugs)
	No changes were made to the DHMO or DPPO Delta Dental plans for 2022. There is a slight premium increase on the DPPO plan.
	No changes were made to VSP's plan for the 2022 plan year. The premium rates will not change for the 2022 plan year.
	Introducing a new diabetes program: Livongo.
	New FSA Vendor: Workterra! Starting in 2022, the administrator for the Flexible Spending Accounts and Transit Accounts will be Workterra. All employees will need to enroll online through Workterra if they wish to enroll or continue in the FSA, commuter and parking accounts for the 2022 plan year. More information regarding this change will be sent via email later this year. **New HSA Contribution Limits!** 2022 HSA contributions limits will increase to $3,650 for Individuals and $7,300 for Family coverage. See page 29 for more information. 2022 HealthCare and Dependent Care FSA contribution limits increases have not been announced by the IRS. These increases typically are announced in October.

Virtual Open Enrollment

The Superior Court will not be hosting any onsite Open Enrollment meetings. All Open Enrollment will be virtual. Make sure to look for emails with more enrollment information. To view the Open Enrollment presentation, go to https://www.brainshark.com/alliant/sbsc2022oe or click on the picture.

Livongo For Diabetes

Chronic Condition Care

Livongo for Diabetes makes diabetes management simple. This new and personalized experience helps members understand their blood sugar, develop healthy lifestyle habits, and improve glycemic control. This program is administered by Express Scripts and is only available to members on a Blue Shield EPO Plan. HDHP plan members are not eligible.

Why Livongo For Diabetes?

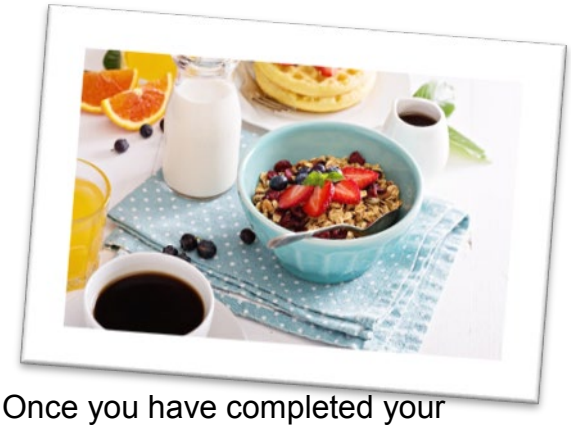
Livongo uses data and technology to monitor your personal health status and give you support when you need it. Coaching and recommendations tailored to your specific needs will help you manage your diabetes in the long term.

How Do I Sign Up?

To sign up or to learn more, visit **welcome.livongo.com/prism** now or call Livongo Member Support at **(800) 945-4355** and have the **registration code PRISM** ready.

Make sure to have the following information:

- **Personal information:** Name, Address, Email, Password
- **Insurance Information:** Pharmacy ID to validate eligibility
- **Health Profile:** To create a tailored experience from the start of the program



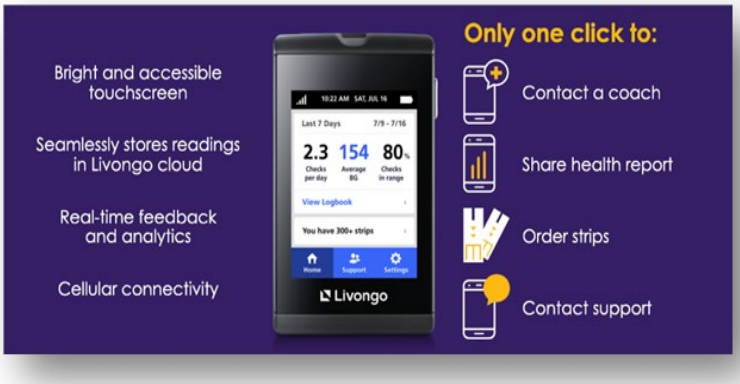
Once you have completed your registration, you will be prompted to download the mobile app as part of the enrollment process.

What You get With Livongo:

Effortless data collection: Members will receive a free cellular meter that provides real-time feedback for glucose readings, and unlimited strips and lancets. This tool will remove barriers for checking your glucose levels, as well as offering food and activity tracking to understand your lifestyle habits.

Personalized health signals: Members will have access to health challenges to drive small daily changes that can result in big wins. The Health Nudges™ feature will interpret members' health metrics, social determinants, preferences, clinical needs and more to trigger timely and actionable feedback to drive behavior change.

Human-centered approach: Members have 24/7 remote monitoring with emergency outreach in the event of an out of range reading as well as access to one on one live coaching from Livongo expert coaches.



Flu Shot Clinics

The Superior Court will be hosting a series of flu and pneumonia shot clinics at all Court locations. EPO members, please bring your Express Scripts ID card with you if you would like a free vaccination. HDHP members, please bring your Blue Shield ID card. **Due to COVID-19, you must complete the Rite Aid Screening Questionnaire and Consent form ahead of time and bring it to the clinic. We will not have pens or forms available at the events. We also ask that you observe social distancing when in line and wear a mask.**

Lompoc, CA
October 19
Lompoc Superior Court, Dept. 2
115 Civic Center Plaza
3:00pm – 5:00pm
Santa Barbara
October 20
Santa Barbara Video Conference Room
118 E. Figueroa St., SB
3:00pm – 5:00pm
Santa Maria, CA
October 21
Santa Maria Judicial Conference Room
312 E. Cook Street
3:00pm – 5:00pm

Benefit Plan Information for 2022

The Superior Court will not be making plan changes to any of the offered benefit plans for the 2022 plan year. All current benefits will remain the same.

Starting January 1, 2022, Workterra will be the new vendor for the Flexible Spending Account and Transit Account.

- To enroll or re-enroll in the medical, dependent care, commuter and/or parking accounts, you must do so **online** at **https://workterra.net**.
- More information including when new debit cards will be issued will be sent via email later this year.

If you would like to keep your current benefit selections, you do not have to do anything during Open Enrollment unless you want to participate in a Flexible Spending Account (FSA) for 2022.

During Open Enrollment, remember that:

- You must enroll in an FSA account every year; your account does not roll over.
- The Courts will continue to contribute $900 ($37.50 per pay period) to a Health Savings Account for all employees enrolled in the Blue Shield HDHP.
- Premium information is on page 13. Most deductions are taken twice monthly rather than every paycheck. For those benefits, there are no deductions in pay period 1 or pay period 14.
- All plan changes must be made online at **https://workterra.net**. You may add, delete, or change all benefit plans online. Instructions on how to use Workterra can be found on the Human Resources web page. All changes must be completed by **October 31, 2021**.

To view the Open Enrollment video, please go to **https://www.brainshark.com/alliant/sbsc2022oe** or click on the picture below.

Who Can You Cover?

WHO IS ELIGIBLE?

Regular Court employees working at least 20 hours per week are eligible for the benefits outlined in this overview.

You can enroll the following family members in our medical, dental and vision plans.

- Your spouse (the person who you are legally married to under state law, including a same-sex spouse).
- Your registered domestic partner is eligible for coverage if you have completed a Domestic Partner Affidavit. Please review the affidavit carefully because it includes important information about the guidelines for adding, ending or changing coverage for your domestic partner. Any premiums for your domestic partner paid for by the Santa Barbara County Superior Court are taxable income and will be included on your W-2. Any premiums you pay for your domestic partner will be deducted on an after-tax basis.
- Your children (including your registered domestic partner's children):
    - Under the age of 26 are eligible to enroll in medical coverage. They do not have to live with you or be enrolled in school. They can be married and/or living and working on their own.
    - Over age 26 ONLY if they are incapacitated due to a disability and primarily dependent on you for support.
    - Named in a Qualified Medical Child Support Order (QMCSO) as defined by federal law.

PROOF OF ELIGIBILITY

Proof of eligibility is required before enrollment of dependents. Eligible documents include:

- Marriage Certificate
- Declaration of Domestic Partnership
- Birth Certificate

See page 38 for more documentation information.

WHO IS NOT ELIGIBLE?

Family members who are not eligible for coverage include (but are not limited to):

- Parents, grandparents, and siblings.

Please refer to the Appendix section on page 35 to obtain detailed information on eligibility requirements and documentation needed.

WHEN CAN I ENROLL?

Coverage for new employees begins on the 1st of the month following their date of hire.

Open enrollment for current employees is held in October. Open enrollment is the one time each year that employees can make changes to their benefit elections without a qualifying life event.

Make sure to notify Human Resources right away if you do have a qualifying life event and need to make a change (add or drop) to your coverage election. These changes include (but are not limited to):

- Birth or adoption of a baby or child
- Loss of other healthcare coverage
- Eligibility for new healthcare coverage
- Marriage
- Divorce

You have 31 days to make your change.

Know Where to Go

ER or Urgent Care?

The emergency room shouldn't be your first choice unless there's a true emergency.

Consider urgent care for...	Go to the emergency room for...
Symptoms, pain or conditions that require quick medical attention but do not require hospital care, such as: - Earache - Sore throat - Rashes - Sprains - Broken fingers or toes - Flu - Fever up to 104 degrees	Serious or life threatening conditions that require immediate treatment that you can get only at a hospital, such as: - Chest pain or severe abdominal pain - Trouble breathing - Loss of consciousness - Severe bleeding that can't be stopped - Large broken bones - Major injuries from a car crash, fall or other accident - Fever above 104 degrees

Is It Preventive or Diagnostic?

You benefit both financially and health-wise when you get annual medical checkups. Preventive care helps you avoid more serious and costly health problems down the road. Plus, it's fully covered in-network.

But did you know that, depending on the situation, the same test or service can be considered preventive (100% covered) or diagnostic (you share the cost)?

Preventive care services

- Help you stay healthy by checking for disease before you have symptoms or feel sick
- Can include flu shots and other vaccinations, physical exams, lab tests and prescriptions
- 100% covered when delivered by an in-network provider

Diagnostic services

- Check for disease after you have symptoms or because of a known health issue
- Can also include physical exams, lab tests and prescriptions
- You pay your share of the cost

Can't get to the doctor's office? Have your visit online!

Have you ever needed to see a doctor but couldn't because of scheduling, holidays, weekends, travel or even bad weather? Online saves you both time and money by connecting you to a board-certified physician via video chat from any location, 24/7, no appointment needed. In just a few minutes, you'll be connected to a doctor who can diagnose, treat, and prescribe medications for many common medical problems such as colds and flu, headache, minor rashes, allergies, digestive issues, and more. Visit **www.teladoc.com/bsc**.

Medical

Medical coverage provides you with benefits that help keep you healthy, like preventive care screenings and access to urgent care. It also provides important financial protection if you have a serious medical condition.

Santa Barbara County Superior Court gives you a choice between two medical plans through Blue Shield of California.

	Blue Shield Medical EPO	Blue Shield Medical – HDHP (High Deductible Health Plan)	
	In-Network	**In-Network**	**Out-Of-Network**
Annual Deductible	$0 - Individual $0 - Family	$1,500 - Individual $3,000 - Family	$1,500 (combined with in-network) $3,000 (combined with in-network)
Annual Out-of-Pocket Max	$1,500 - Individual $3,000 - Family	$4,500 - Individual $9,000 - Family	$4,500 (combined with in-network) $9,000 (combined with in-network)
Lifetime Maximum	Unlimited	Unlimited	Unlimited
Office Visit			
Primary Provider	$20 copay	Plan pays 80% after deductible	Plan pays 60% after deductible
Specialist	$20 copay	Plan pays 80% after deductible	Plan pays 60% after deductible
Home Visit	$50 copay	Plan pays 80% after deductible	Plan pays 60% after deductible
Virtual Visit - Teladoc	$20 copay	$40 copay after deductible	Not Covered
Preventive Services	Plan pays 100%	Plan pays 100%	Plan pays 60% after deductible
Chiropractic Care	$20 copay (combined outpatient rehab up to 30 visits/ cal year)	Plan pays 80% after deductible (up to 20 visits per calendar year)	Plan pays 60% after deductible (combined with in-network limit of 20 visits/calendar year)
Lab and X-ray	Plan pays 100%	Plan pays 100% after deductible	Plan pays 60% after deductible
Inpatient Hospital Stay and Services	$250/ admission then plan pays 80%	Plan pays 80% after deductible	Plan pays 60% after deductible (up to $600 per day)
Outpatient Surgery	Plan pays 100%	Plan pays 80% after deductible	Plan pays 60% after deductible (up to $350 per day)
Urgent Care	$20 copay	Plan pays 80% after deductible	Plan pays 60% after deductible
Emergency Room	$100 copay then plan pays 100% (copay waived if admitted)	Plan pays 80% after deductible	Plan pays 80% after deductible

Prescription Drugs

Prescription drug coverage provides a benefit that is important to your overall health. If you enroll in medical coverage, you will automatically receive coverage for prescription drugs. Here are the prescription drug plans that are offered with our Blue Shield EPO and HDHP plans.

	Blue Shield EPO (Administered by Express Scripts)	Blue Shield HDHP (Administered by Blue Shield)	
	In-Network	**In-Network**	**Out-Of-Network**
Prescription Drug Deductible	$25 per individual; $75 per family for Preferred and Non-Preferred Brand	Combined with medical	Combined with medical
Annual Out-of-Pocket Limit	$5,100 Ind/$10,200 family	Combined with medical	Combined with medical
Pharmacy			
Tier 1 Drugs (Generic)	$10 copay	Plan pays 80% after deductible	Plan pays 80% after deductible
Tier 2 Drugs (Preferred Brands)	$35 copay after Rx deductible	Plan pays 80% after deductible	Plan pays 80% after deductible
Tier 3 Drugs (Non - Preferred Brands)	$50 copay after Rx deductible	Plan pays 80% after deductible	Plan pays 80% after deductible
Tier 4 Drugs (Specialty Drugs)	Plan pays 80% w/ $100 copay max	Plan pays 80% w/ $100 copay max	Plan pays 80% w/ $100 copay max
Supply Limit	30 days	30 days	30 days
Mail Order			
Tier 1 Drugs (Generic)	$20 copay	Plan pays 80% after deductible	Not covered
Tier 2 Drugs (Preferred Brands)	$70 copay after Rx deductible	Plan pays 80% after deductible	Not covered
Tier 3 Drugs (Non - Preferred Brands)	$100 copay after Rx deductible	Plan pays 80% after deductible	Not covered
Tier 4 Drugs (Specialty Drugs)	Plan pays 80% w/ $100 copay max	Plan pays 80%w/ $200 copay max	Not Covered
Supply Limit	90 days	90 days	Not applicable

Dental

Regular visits to your dentist can protect more than your smile; they can help protect your health. Recent studies have linked gum disease to damage elsewhere in the body and dentists are able to screen for oral symptoms of many diseases including cancer, diabetes, and heart disease.

The Santa Barbara County Superior Court gives you a choice between two dental plans through Delta Dental. **Important:** Delta Dental does not issue ID Cards. Please refer to the Court's custom Delta Dental website to download and print your ID card. Members can also view their plan coverage and benefits, locate a provider, and more at **www.deltadentalins.com/superiorcourtofcactyofsantabarbara**.

If you elect the DHMO plan, you must select a DeltaCare USA primary dentist, otherwise, you will be auto assigned a dentist near your home zip code.

	Delta Dental DHMO - DeltaCare USA	Delta Dental PPO	
DELTA DENTAL	**In-Network**	**In-Network***	**Delta Dental Premier or Out-Of-Network***
Calendar Year Deductible	$0 - Individual $0 - Family	$50 - Individual $100 - Family	$50 – Individual (combined with in-network) $100 – Family (combined with in-network)
Annual Plan Maximum	N/A	$1,500 per person	$1,500 per person (combined with in-network)
Waiting Period	None	None	None
Diagnostic and Preventive	Plan pays 100%	Plan pays 100%	Plan pays 100%
Basic Services			
Fillings	Various copays apply	Plan pays 90% after deductible	Plan pays 80% after deductible
Root Canals	Various copays apply	Plan pays 90% after deductible	Plan pays 80% after deductible
Periodontics	Various copays apply	Plan pays 90% after deductible	Plan pays 80% after deductible
Major Services	Various copays apply	Plan pays 60% after deductible	Plan pays 50% after deductible
Orthodontic Services			
Orthodontia	Plan pays 100% up to Lifetime Maximum	Plan pays 50% up to $1,500 Lifetime Maximum (Calendar deductible does not apply)	Plan pays 50% up to $1,500 Lifetime Maximum (Calendar deductible does not apply)
Lifetime Maximum	$1,900 Child $2,100 Adult	$1,500 Child $1,500 Adult	$1,500 Child or Adult (combined with in-network)

*Reimbursement is based on PPO contracted fees for PPO dentists, Premier contracted fees for Premier dentists and 80th percentile for non-Delta dentists.

Vision

Routine vision exams are important, not only for correcting vision but because they can detect other serious health conditions.

We offer you a vision plan through Vision Service Plan (VSP).

	VSP Vision	
	In-Network	**Out-Of-Network***
Examination		
Benefit	$10 copay then plan pays 100%	Plan pays up to $45
Frequency	1 x every 12 months	In-network limitations apply
Eyeglass Lenses		
Single Vision Lens	$10 copay then plan pays 100% of basic lens	Up to $30
Bifocal Lens	$10 copay then plan pays 100% of basic lens	Up to $50
Trifocal Lens	$10 copay then plan pays 100% of basic lens	Up to $65
Frequency	1 x every 24 months	In-network limitations apply
Frames		
Benefit	Up to $120 Up to $70 at Costco 20% off amount over your allowance	Up to $70
Frequency	1 x every 24 months	In-network limitations apply
Contacts (In Lieu of Glasses)		
Benefit	Up to $120	Up to $105
Frequency	1 x every 24 months	1 x every 24 months

*The Out-of-Network amounts are reimbursement amounts not copayment amounts.

USING YOUR VSP BENEFIT IS EASY

- Find a VSP doctor at **www.vsp.com** under the VSP Signature network.
- At your appointment, say you have VSP. No ID card required, but you can print one online.

GO TO WALMART!

The Walmart frame allowance will be $70, contact lenses will be the same as current benefit (up to $120 allowance). Note that discounts on lens options will not apply at Walmart.

Cost of Coverage

The amount that you pay for your coverage is outlined below and depends on whether you have employee only coverage or cover dependents.

In general, you pay for health coverage before federal, state, and social security taxes are withheld, so you pay less in taxes. Please note that domestic partner contributions are regulated by the IRS and generally must be made on an after-tax basis. Similarly, the company contribution toward the cost of domestic partner coverage and his/her dependents is taxable income to you. Contact your tax advisor for more details on how this tax treatment applies to your specific situation.

Rates noted below are twice monthly.

	Medical Premium	Court Contribution*	Pre-Tax Employee Cost	After-Tax Employee Cost
Blue Shield EPO Medical Plan Group #W0052121				
Employee Only	382.00	(382.00)	0.00	
With 1 Dependent	707.50	(382.00)	325.50	
Two + Dependents	1,110.00	(382.00)	728.00	
Employee + Domestic Partner	707.50	(382.00)	0.00	325.50
Employee + 1 Dep & Domestic Partner	1,110.00	(382.00)	325.50	402.50
Employee + 2 or more Dep & Dom Partner	1,110.00	(382.00)	728.00	
Blue Shield HDHP Medical Plan Group #W0052151				
Employee Only	337.50	(337.50)	0.00	
With 1 Dependent	624.00	(337.50)	286.50	
Two + Dependents	981.00	(337.50)	643.50	
Employee + Domestic Partner	624.00	(337.50)	0.00	286.50
Employee + 1 Dep & Domestic Partner	981.00	(337.50)	286.50	357.00
Employee + 2 or more Dep & Dom Partner	981.00	(337.50)	643.50	

*Court contribution will be pro-rated for part-time employees.

Rates noted below are twice monthly.

	Dental Premium	Court Contribution*	Pre-Tax Employee Cost	After-Tax Employee Cost
Delta Dental PPO Group #16479				
Employee Only	23.40	(13.02)	10.38	
With 1 Dependent	44.90	(13.02)	31.88	
Two + Dependents	69.00	(13.02)	55.98	
Employee + Domestic Partner	44.90	(13.02)	10.38	21.50
Employee + 1 Dep & Domestic Partner	69.00	(13.02)	31.88	24.10
Employee + 2 or more Dep & Dom Partner	69.00	(13.02)	55.98	
Delta Dental HMO DeltaCare USA, Group #76836				
Employee Only	20.17	(13.02)	7.15	
With 1 Dependent	33.16	(13.02)	20.14	
Two + Dependents	50.32	(13.02)	37.30	
Employee + Domestic Partner	33.16	(13.02)	7.15	12.99
Employee + 1 Dep & Domestic Partner	50.32	(13.02)	20.14	17.17
Employee + 2 or more Dep & Dom Partner	50.32	(13.02)	37.30	

*Court contribution will be pro-rated for part-time employees

	Vision Premium		Pre-Tax Employee Cost	After-Tax Employee Cost
Vision Service Plan (VSP)				
Employee Only	3.50	N/A	3.50	
With 1 Dependent	4.90	N/A	4.90	
Two + Dependents	8.65	N/A	8.65	
Employee + Domestic Partner	4.90	N/A	3.50	1.40
Employee + 1 Dep & Domestic Partner	8.65	N/A	4.90	3.75
Employee + 2 or more Dep & Dom Partner	8.65	N/A	8.65	

Life and Disability Insurance

If you have loved ones who depend on your income for support, having life and accidental death insurance can help protect your family's financial security.

BASIC LIFE

Basic Life Insurance pays your beneficiary a lump sum if you die. The cost of coverage is paid in full by the Courts. Coverage is provided by Voya Financial.

Basic Life Amount	$20,000

LONG-TERM DISABILITY

The Courts cover all regular employees working 20 hours or more with a Long-Term Disability Insurance plan. The plan pays 60% of your monthly earnings with a minimum of $100 to a maximum amount which is dependent on your job classification. You must be disabled for 60 days before the plan begins to pay benefits.

VOYA FINANCIAL

SUPPLEMENTAL LIFE and AD&D

Supplemental Life and AD&D Insurance allows you to purchase additional life insurance to protect your family's financial security. Coverage is provided by Voya Financial.

Employee Supplemental Life Amount	Can elect from **$20,000** to **$500,000** in increments of **$10,000** ($10,000 of AD&D is included for a minimal fee)
Spouse or Domestic Partner Supplemental Life Amount	Can elect from **$20,000** to **$500,000** in increments of **$10,000** not to exceed 100% of Employee's Supplemental Life Insurance amount. Employee must have coverage.
Child(ren) Supplemental Life Amount	Can elect **$5,000 or $10,000** (unmarried child from birth up to age 26). Employee must have coverage.

NOTE: Your amount of Supplemental Life and AD&D will decrease to 65% on your 65th birthday, to 50% of original coverage on your 70th birthday and 30% of the original coverage at age 75.

Beneficiary Reminder: Make sure that you have named a beneficiary for your life insurance benefit. It's important to know that many states require that a spouse be named as the beneficiary, unless they sign a waiver.

Evidence of Insurability: Depending on the amount of coverage you select, you may need to submit an Evidence of Insurability form, which involves providing the insurance company with additional information about your health.

Taxes: Due to IRS regulations, a life insurance benefit of $50,000 or more is considered a taxable benefit. You will see the value of the benefit included in your taxable income on your paycheck and W-2.

NOTE: Rates for this plan can be found on page 22.

Voluntary Accident and Critical Illness Insurance

VOLUNTARY PERSONAL ACCIDENT

Voluntary Personal Accident Insurance (PAI) is offered by Voya Financial. Premiums are based on a flat rate per $1,000 for Employee only or Family (Spouse/Domestic Partner and Child coverage). Evidence of Insurability (EOI) is not required. Rates for this plan can be found on page 19.

Employee Voluntary Personal Accident	Can elect from $25,000 to $300,000 in $25,000 increments not to exceed 10 times annual salary
Family Voluntary Personal Accident	• Spouse/Domestic Partner – receives 50% of Employee's Personal Accident Insurance • Child (each) – receives 10% of Employee's Personal Accident Insurance

VOLUNTARY COMPASS ACCIDENT

Voluntary Compass Accident Insurance is offered by Voya Financial. This policy helps you pay for the out-of-pocket costs you may experience after an accident. The policy pays a lump sum amount depending on the type of injuries you have sustained such as broken bones, torn ligaments or burns, as well as for expenses from hospitalizations, the ER, office visits or physical therapy. You may use this amount to pay for everyday living expenses or to pay healthcare costs. **The policy also has an annual Wellness Benefit that pays you $100 for completing a screening, an additional $100 for a covered spouse and $50 for a child.**

VOLUNTARY CRITICAL ILLNESS

Critical Illness Insurance is an affordable way to protect against the financial stress of a serious illness. It pays a lump-sum benefit if you are diagnosed with a covered illness or condition. This policy is in addition to your health coverage. You may use this benefit to pay:

- Medical expenses
- Child Care
- Home health costs
- Mortgage payment/rent and home maintenance
- Any other every day expenses

This policy offers an annual Wellness benefit that provides a $150 reimbursement for each covered employee and spouse who completes a covered health screening. Child benefit is 50% of employee amount with a maximum of $300 in child wellness benefit.

Coverage is provided by Voya Financial.

Employee Voluntary Critical Illness	Can elect from $5,000 to $20,000 in $5,000 increments.
Spouse Voluntary Critical Illness	Can elect $5,000 or $10,000. Must have employee coverage.
Child Voluntary Critical Illness	Can elect $1,000. $2,500. $5,000 or $10,000. Must have employee coverage.

VOYA – Voluntary Hospital Confinement Indemnity Plan

Voya is offering their Compass Hospital Confinement Indemnity plan which provides a benefit for a hospital stay. This voluntary benefit is separate from your Blue Shield hospital benefit. This Voya plan pays a daily benefit if you have a covered stay in a hospital, critical care unit or rehabilitation facility. The benefit is determined by the type of facility and the number of days you stay. You can use the lump sum payment for any purpose such as deductible, copays or everyday expenses like utilities and groceries. Plan rates are noted on page 22.

Plan highlights:

- Guarantee issue – no medical question or tests required
- Flexible – you can use the benefit payments for any purpose you like
- Portable – you can take the policy with you if you leave your employer or retire

Benefit	
Initial Hospital admission	$1,000
Hospital	$100 per day up to 30 days per confinement
Critical Care Unit	$200 per day up to 15 days per confinement
Rehabilitation Facility	$50 per day up to 30 days per confinement
Pre-existing condition limitation	None
Age reduction	None
Portability	You can take this policy with you if you leave the Court
Wellness Benefit	
Employee	$50, once a year
Spouse	$50, once a year
Child	$25 per child, to a maximum of $100, once a year

The Wellness benefit provides an annual amount if you complete a preventive health screening test. Refer to page **18** for information on what are Preventive health screening tests.

VOYA FINANCIAL

If viewing electronically, click on the icon to view a video on the Hospital Indemnity Plan or go to our website where you will find an electronic copy of this booklet.

Wellness Benefit at a Glance

What is a Wellness Benefit?

A Wellness benefit is a rider that is included on your voluntary Accident, Critical Illness and Hospital Indemnity Plan. It provides an annual payment if you complete a preventive health screening test. You only need to complete one preventive health screening test. This one test can be used for any or all three benefit plans. The Accident, Critical Illness and Hospital Indemnity plan each has a Wellness benefit. Your spouse and/or dependents covered under your plan also have a Wellness benefit.

What type of preventive health screening tests are eligible?

Preventive health screening tests include but are not limited to:

Blood test for triglycerides	Serum Protein Electrophoresis	Fasting blood glucose test	Annual physical exam
Pap smear	Breast ultrasound, sonogram, MRI	Thermography	CA 125 (ovarian cancer)
Sigmoidoscopy	Chest x-ray	PSA (prostate cancer)	Tests for STIs
CEA (blood test for colon cancer)	Mammography	Hearing test	Ultrasounds for abdominal aortic aneurysms
Bone marrow testing	Colonoscopy	Routine eye exam	Hemoglobin A1C
Cholesterol test	CA 15-3 (breast cancer)	Routine dental exam	Bone density
Hem occult stool analysis	Stress test on bicycle or treadmill	Well child/preventive exam to age 18	Electrocardiogram (EKG)

How do I file a claim?

You can easily file a claim online.

1. Go to voya.com/claims
2. Scroll down to the “Have a Wellness Benefit Claim?” section and click the “Submit your claim” button.
3. Check all products that apply – Accident, Critical Illness, Hospital Indemnity
4. Click “Continue” and follow the screen prompts. Once all questions are answered, click “Submit”

Your Group Name is: Santa Barbara Superior Court

Your Group Number is: 00680974

Don’t forget to claim your Wellness dollars every year!

Make it a habit to do so right after your annual physical exam.

If viewing electronically, click on the icon to view a video on How To File A Claim or go to our website where you will find an electronic copy of this booklet.

Voluntary Insurance Rates

Supplemental Life Insurance Rates

Semi-Monthly (24)

Employee and Spouse Supplemental Life Insurance Rates	
Age	**Cost per $1,000 of Coverage**
Under 25	$0.03
25-29	$0.03
30-34	$0.045
35-39	$0.05
40-44	$0.06
45-49	$0.09
50-54	$0.165
55-59	$0.26
60-64	$0.405
65-69	$0.775
70+	$1.255

Supplemental Accidental Death and Dismemberment (AD&D) Insurance Rates	
Coverage Type	**Cost of Coverage**
Employee Supplemental AD&D	$0.13

Child Life Insurance Rates	
Coverage Levels	**Cost of Coverage**
$5,000 each child	$0.525
$10,000 each child	$1.05

Personal Accident Insurance (PAI) Rates

Semi-Monthly (24) Rates

Coverage Type	Cost per $1,000 of Coverage
Employee Only	$0.02
Employee + Family	$0.28

Voluntary Compass Accident Insurance Rate

Semi-Monthly (24) Rates - Includes Wellness

Employee	Employee and Spouse	Employee and Children	Family
$4.57	$7.58	$8.10	$11.10

Voluntary Hospital Confinement Indemnity Insurance Rate

Semi-Monthly (24)

Coverage Type	
Employee Only	$13.59
Employee + Spouse	$26.52
Employee + Child(ren)	$20.15
Employee + Family	$33.08

Voluntary Critical Illness Insurance Rates

Employee Coverage - Semi-Monthly (24) Rates - Includes Wellness Benefit

Non-Tobacco					Tobacco				
Issue Age	$5,000	$10,000	$15,000	$20,000	Issue Age	$5,000	$10,000	$15,000	$20,000
Under 20	$3.70	$5.45	$7.20	$8.95	Under 20	$4.95	$7.95	$10.95	$13.95
20-24	$3.70	$5.45	$7.20	$8.95	20-24	$4.95	$7.95	$10.95	$13.95
25-29	$3.98	$6.00	$8.03	$10.05	25-29	$5.50	$9.05	$12.60	$16.15
30-34	$4.05	$6.15	$8.25	$10.35	30-34	$5.85	$9.75	$13.65	$17.55
35-39	$4.78	$7.60	$10.43	$13.25	35-39	$7.33	$12.70	$18.08	$23.45
40-44	$6.18	$10.40	$14.63	$18.85	40-44	$10.10	$18.25	$26.40	$34.55
45-49	$8.08	$14.20	$20.33	$26.45	45-49	$13.85	$25.75	$37.65	$49.55
50-54	$10.25	$18.55	$26.85	$35.15	50-54	$18.13	$34.30	$50.48	$66.65
55-59	$12.33	$22.70	$33.08	$43.45	55-59	$22.15	$42.35	$62.55	$82.75
60-64	$15.18	$28.40	$41.63	$54.85	60-64	$27.50	$53.05	$78.60	$104.15
65-69	$21.30	$40.65	$60.00	$79.35	65-69	$38.98	$76.00	$113.03	$150.05
70+	$29.58	$57.20	$84.83	$112.45	70+	$54.88	$107.80	$160.73	$213.65

Spouse Coverage -Semi-Monthly (24) Rates - Includes Wellness Benefit

Non-Tobacco			Tobacco		
Issue Age	**$5,000**	**$10,000**	**Issue Age**	**$5,000**	**$10,000**
Under 20	$3.28	$4.60	Under 20	$4.23	$6.50
20-24	$3.28	$4.60	20-24	$4.23	$6.50
25-29	$3.60	$5.25	25-29	$4.93	$7.90
30-34	$4.60	$7.25	30-34	$6.73	$11.50
35-39	$5.50	$9.05	35-39	$8.45	$14.95
40-44	$7.23	$12.50	40-44	$11.88	$21.80
45-49	$9.88	$17.80	45-49	$17.10	$32.25
50-54	$13.48	$25.00	50-54	$24.33	$46.70
55-59	$17.45	$32.95	55-59	$32.20	$62.45
60-64	$22.45	$42.95	60-64	$42.18	$82.40
65-69	$30.93	$59.90	65-69	$58.60	$115.25
70+	$35.98	$70.00	70+	$67.60	$133.25

Children Coverage - Semi-Monthly (24) Rates - Includes Wellness Benefit

Coverage Amount	Rate
$1,000	$1.84
$2,500	$2.34
$5,000	$3.18
$10,000	$4.85

Stay Connected With Your Wellness Resources

The COVID-19 pandemic has brought new challenges and stresses to our lives. During this unprecedented time, the Courts would like to highlight the various benefits and resources that you have available from our benefit carriers. Now is a good time to utilize the many benefit options as virtual appointments, free online wellness classes and EAP services.

EMPLOYEE ASSISTANCE PROGRAM

There are times when everyone needs a little help or advice. The confidential Employee Assistance Program (EAP) through MHN Inc. can help you with things like stress, anxiety, depression, chemical dependency, relationship issues, legal issues, parenting questions, financial counseling, and dependent care resources. Best of all, it's free for you and your family.

Take charge of your well-being! MHN can help. Just register on the member website to:

- Assess your health and get tips for living better
- Track progress toward your wellness goals
- Take advantage of interactive e-learning programs
- Find articles and videos about health topics

Need Help?

Call toll-free, 24 hours a day, seven days a week: **(800) 242-6220**

TTY users call 711.

Or visit us at: **members.mhn.com**

Company code: **sbcountycourts**

We offer counseling sessions face-to-face, over web video, or over the phone.

Call the EAP number or visit the member portal to learn more about MHN's wellness coaching services and all their other services!

	EAP Benefits
Face-to-Face Counseling	3 Sessions per participant per issue
Telephonic Assistance	Unlimited telephonic access to counselors, 24/7/365
Financial Counseling	One 30 – 60 minute telephonic consultation per issue
Legal Consultations	One 30 minute consultation per issue (telephonic or office) For those who wish to engage with an attorney after a 30 minute session, will receive a 25% discount on the hourly rate
Substance Abuse	30 minute sessions/unlimited issues (telephonic or office)

TELADOC - Accessing Medical and Behavioral Telemedicine

Teladoc is a convenient way to access medical and behavioral health care and is available to all **Blue Shield members**. U.S. certified doctors are available 24/7/365 to resolve non-emergency issues via phone or video consults.

When should I use Teladoc?	What kind of symptoms can be treated?	How much will I pay?	How do I get started?
• **If you are considering the ER or urgent care center for a non-emergency** • **When on vacation, a business trip or away from home** • **For short-term prescription refills**	Teladoc doctors and therapists can treat many medical conditions, including: • Cold and flu symptoms • Allergies • Bronchitis • Urinary tract infection • Respiratory infection • Sinus problems • Depression • Anxiety	**EPO Members**: $20 copay per consult **HDHP Members:** Members pay a $40 consult fee after the deductible is met.	1. **Set up an account.** Visit teladoc.com/bsc, complete the required information and click on *Set up account*. 2. **Provide medical history.** Your medical history provides doctors with the information they need to make an accurate diagnosis. 3. **Request a consult.** Once your account is set up, request a consult anytime you need care.

Behavioral health providers are available from the privacy of your home or wherever you are most comfortable.

- Talk to a therapist or psychiatrist when you are feeling anxious, stressed, down or not like yourself.
- Access mental health support. If your mental health condition isn't improving, get guidance for the right specialists to progress your treatment.

Visit Teladoc.com/bsc and set up an account or call 1.800.835.2362

TELADOC blue california

WELLVOLUTION

Take control of your health with Wellvolution® – the digital platform that guides you in your health journey.

Included with Blue Shield plans at no additional cost, Wellvolution can help you feel your best with:

- Best-in-class well-being apps and health programs
- Guidance for treatment-related decisions
- Personalized coaching and support

Ways to meet your health goals

Whether you're a CrossFit buff or a committed couch potato, love trending plant-based diets or are a die-hard carnivore, Wellvolution has something just for you. Our library of apps and programs – both digital and in-person – can help you:

- Prevent and treat disease
- Lose weight
- Manage stress
- Sleep better
- Eat healthier
- Stop smoking

Wellvolution is useful for: Getting to your ideal weight, normalizing blood pressure, lowering cholesterol, reversing type 2 diabetes, and more.

Programs include:

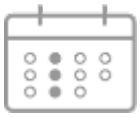
- WW — diabetes prevention
- restore HEALTH — Weight management and lifestyle change
- digbi health — Weight and diabetes management
- habitnu — Culturally competent diabetes prevention and weight management
- HealthSlate — Diabetes prevention & management and weight management
- virta — Diabetes management
- Yes HEALTH — Diabetes prevention and weight management

Change your health, change your life.
Visit **wellvolution.com** to get started.

SOLERA – Lifestyle Change Program

Blue Shield offers a **free** comprehensive 16-week program which helps qualified members lose weight, adopt healthy habits and significantly reduce their risk of developing type 2 diabetes. The program meets weekly for 16 weeks and then monthly for the balance of the year. You may choose from an array of national programs like Weight Watchers, Jenny Craig, Retrofit or HealthSlate. To find out if you qualify for this preventive program, go to www.solera4me.com/bsca and take a one minute quiz. If you qualify, use Blue Shield of CA as your health plan and your Blue Shield Member ID number to enroll.

Health Coaching



Weekly Lessons

Integrated devices

Group Support

Call Solera at **877.486.0141** if you have questions.

SOLERA4ME

CARRUM HEALTH – Voluntary Surgery Benefit

Carrum Health, your voluntary surgery benefit, has inpatient and outpatient surgeries at Centers of Excellence medical centers. 80 outpatient procedures are available at Hoag Orthopedic Institute in Orange County. Inpatient surgeries are at Stanford Healthcare, Scripps Health Hospital and St. Johns Health Center.

Why Carrum?

- Highest quality surgeons
- No medical bills! Coinsurance and deductible waived*
- Travel expenses covered 100% for two
- Your own personal Concierge that will:
  - Help with forms
  - Gather medical records
  - Schedule surgery
  - Make travel arrangements
  - Coordinate post-discharge care

*Due to IRS regulations on HDHP plans, the deductible applies but the coinsurance is waived.

Important: total joint replacement, spinal fusion and bariatric (weight loss) surgeries will be required to have a complimentary second opinion evaluation through the Carrum Health Program.

FIND OUT MORE:
Visit: carrum.me/PRISM
Text: "EIA" to 555888
Call us: 1-888-855-7806

CarrumHealth
Better Surgeons, Better Results

WE INVITE YOU TO PLAY

QUIZZIFY

AN ONLINE TRIVIA GAME THAT CAN SAVE YOU MONEY AND IMPROVE YOUR HEALTH!

Did you know...

long-term daily use of heartburn pills, like **Nexium, Prevacid, and Prilosec** could affect your **bone, kidney and heart health**?

taking OTC sleeping aids like **Tylenol PM or Benadryl** on a long-term daily use **may increase health risks** like dementia?

57% of Americans received a **surprise medical bill** within the last 5 years? And the most common bills come from emergency room visits?

Quizzify helps prepare you to advocate for yourself as a healthcare consumer.

Through monthly quizzes it shows you how to **improve your lifestyle**, and **avoid potentially harmful medical care...** all with a little added humor!

Learn more by visiting our blog at:

sbcourts.quizzify.com

Quizzes are reviewed by Harvard Medical School physicians

NO COST ONLINE WELLNESS RESOURCES – Available to Everyone

PHYSICAL HEALTH

There are many online tools to make exercising at home, fun and effective. Exercise is important for overall heathy well-being, but it is vital to protect yourself from airborne disease. Below are free fitness activities to try from your home. These are independent from your medical carriers.

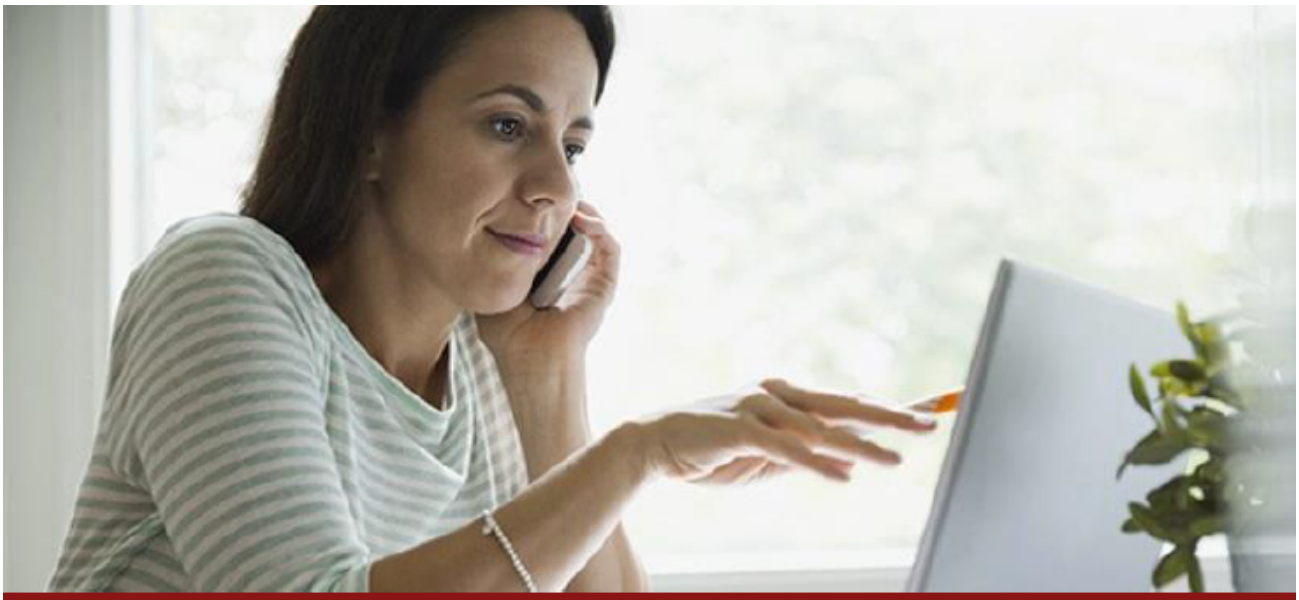
Yoga & Pilates	
Corepower Yoga	Access free classes through their **YouTube channel**.
Total Body	
Active by POPSUGAR app	**Sign up for free here** to get hundreds of do-anywhere workouts.
Les Mills	**Free at home workouts**.
Running, Dance	
Couch to 5K App	For those that want to improve on running.
Fitness Marshall	Get ready to sweat with **Fitness Marshall**.
Rhythm and Motion	Free **1-hr dance workout videos** for all levels.
MadFit	Great at **home workouts**.
Strength Training	
BodyFit by Amy	At **home workouts**, both body weight and with dumbbells/kettlebells.
8-min buns	No equipment needed for this **video**.

MENTAL / EMOTIONAL HEALTH

Without a doubt, many of us are feeling anxious as we navigate the uncertainty of COVID-19. Here are some tools that you can use to take care of your mind and stay grounded. No insurance required.

Meditation and Mindfulness	
Insight Timer	The app features guided meditations, music and talks by contributing experts. Basic service is free.
Simple Habit	A free medication app that offers short meditation sessions designed to help busy people manage stress and live better.
Headspace	Train your mind and body for a healthier, happier life with this app. Both a free (meditations, exercises) and buy-up option.
Resilience and Stress Management	
Podcasts	The Happyness Lab, Ten Percent Happier with Dan Harris, Oprah's Super Soul Conversations podcasts. Inspiring stories, messages and research around happiness and daily tips to brighten one's outlook.
Playlists	Calm Vibes, Calming Acoustic, Calming Instrumental Covers, Peaceful Piano, Soothe, Calm Classic. Music can have a profoundly relaxing effect on both minds and body.
Courses and Education	
Wellness During Quarantine	Healbright offers a free mental health **course** to address the stress caused by the COVID-19 pandemic.

HEALTHCARE ADVOCACY PROGRAM



CareCounsel Healthcare Advocacy

Who is CareCounsel?

Navigating through the complex healthcare system can be difficult. When issues arise and especially when dealing with your healthcare dollars, you need an expert by your side every step of the way.

CareCounsel is your dedicated advocate with any healthcare benefit issue. Our services are confidential and dedicated to your best interest in reducing hassle and headaches with your healthcare experience.

Our Services:

- Benefits Education
- Open Enrollment Support & Plan Comparisons
- Making Sense of Medicare
- Locating doctors, hospitals and ancillary providers in your network
- Coordinating multiple party interactions
- Troubleshooting claims, eligibility and billing discrepancies
- Grievance and Appeals Support
- Coordinate access to clinical information via Stanford Health Care

CareCounsel Contact Information:

Available: Monday – Friday; 6:30am – 5pm

(888) 227-3334

carecounsel.com

CareCounsel | Stanford HEALTH CARE STANFORD MEDICINE

Scan me

Health Savings Account (HSA)

A Health Savings Account (HSA) is available to employees who participate in the Blue Shield High Deductible Health Plan (HDHP). This is a tax-advantaged savings account through Sterling HSA that allows you to save pre-tax dollars to pay for qualified health expenses.

The Court will contribute $900 annually over 26 pay periods into your Sterling HSA account.

An HSA allows you to:

- Save toward medical expenses (including dental and vision), up to IRS maximums (see Table below)
- Have your contributions deducted on a pre-tax basis
- Change your contribution amount at any time
- Roll the funds to the following year (this is not a “use it or lose it” plan)
- Keep the account; it is portable; it goes with you if you leave employment
- Use a debit card to pay for qualified medical expenses
- Use the funds to pay for IRS tax dependents even if they are not enrolled in the HDHP

NOTE: you are not eligible to elect an HSA if you are covered by another health plan, such as a health plan sponsored by your spouse’s employer (unless it is another HDHP plan), Medicare, Tricare or if an employee is claimed as a dependent on another’s tax return.

HSA Contribution Limits for 2022

Annual Single Contribution Maximum	$3,650*
Annual Family Contribution Maximum	$7,300*
Annual Catch-Up Contribution Maximum (for HSA participants that are 55 years or older)	$1,000

*Limit includes contributions from the Court.

Flexible Spending Account (FSA)

Santa Barbara County Superior Court offers you the opportunity to participate in a Healthcare and/or Dependent Care Flexible Spending Account (FSA). Workterra is the administrator for these accounts. To access your accounts visit, https://WORKTERRA.lh1ondemand.com. For member services, email custserv@WORKTERRAbenefits.com or call 888.327.2770.

HEALTHCARE FSA ACCOUNT

This plan allows you to pay for eligible out-of-pocket healthcare expenses with pre-tax dollars. Eligible expenses include medical, dental, or vision costs including plan deductibles, copays, coinsurance amounts, and other non-covered healthcare costs for you and your tax dependents. For 2022, you can set aside up to $2,750.

Due to IRS guidelines, employees who are enrolled in a HDHP plan cannot have a HealthCare FSA if they also have a Health Savings Account (HSA). For this reason, the IRS does allow you to open a Limited-Purpose Flexible Spending Account where eligible expenses are limited to qualified dental and vision expenses only. You may use this account to pay dental fillings, braces, crowns, vision exams, eyeglasses, vision correction procedures and more.

DEPENDENT CARE FSA ACCOUNT

This plan allows you to pay for eligible out-of-pocket dependent care expenses with pre-tax dollars. Eligible expenses may include day care centers, in-home child care, and before or after school care for your dependent children under age 13. Other individuals may qualify if they are considered your tax dependent and are incapable of self-care. It is important to note that you can access money only after it is placed into your dependent care FSA account.

All caregivers must have a tax ID or Social Security number. This information must be included on your federal tax return. If you use the dependent care reimbursement account, the IRS will not allow you to claim a dependent care credit for reimbursed expenses. Consult your tax advisor to determine whether you should enroll in this plan. For 2022, you can set aside up to $5,000 per household for eligible dependent care expenses.

IMPORTANT CONSIDERATIONS

- The FSA plans have an added feature (Grace Period) that allows you to continue to incur new claims up to 03/15/23, with any remaining funds from your 2022-elected amount. Expenses must be submitted for reimbursement no later than 05/30/23.
- Elections cannot be changed during the plan year, unless you have a qualified change in family status (and the election change must be consistent with the event).
- FSA funds can be used for you, your spouse, and your tax dependents only.
- Keep your receipts. In most cases, you'll need to provide proof that your expenses were considered eligible for IRS purposes.
- You must spend all the monies in your account or you will lose it. You may not carry over an FSA balance from one year to another.

TRANSIT & PARKING FLEXIBLE SPENDING ACCOUNT (FSA)

Santa Barbara County Superior Court allows you to participate in a Parking/Transit Flexible Spending Account. Use the money in our Workterra Commuter Program for all of your eligible work-related transit and parking expenses. Ineligible expenses include tolls, car maintenance, carpools and gasoline.

Work related transit - these consist of vouchers, passes, tokens and fare cards for transportation via bus, commercial vanpool or train.

Parking expenses – these include parking at or near work, parking at or near a transportation site and Park and Ride expenses.

The maximum IRS allowed amount for 2022 is $270 per month.

To learn more about the FSA and Transit/Parking FSA visit: https://www.workterra.com/member-center.html

Note: The 2022 FSA maximum amount may change in October when the IRS announces the maximum limits

Get Educated Virtually!

Get help with your benefits however you feel most comfortable. Below is a list of fun, educational videos where you can learn about different topics that will help you better understand your benefits!

Benefit Terms Explained

How to read an EOB

Top 5 Prescription Dos and Don’ts

High Deductible Health Plan w/ HSA

What is an FSA

Understanding Your Dental Plan

HSA vs FSA

EAP

Primary vs Urgent vs ER

Qualifying Events

Preventive Care

What is Teladoc

For Assistance

Plan Type	Provider	Phone Number	Website
Medical	Blue Shield EPO and HDHP	855.256.9404	www.blueshieldca.com/prism
Pharmacy	Express Scripts for EPO only	800.711.0917	www.express-scripts.com
Medical	Carrum Health	888.855.7806	carrum.me/prism
Dental	Delta Dental DHMO DeltaCare USA	800.422.4234	www.deltadentalins.com/superiorcourtofcactyofsantabarbara
Dental	Delta Dental PPO & Premier	800.765.6003	www.deltadentalins.com/superiorcourtofcactyofsantabarbara
Vision	Vision Service Plan (VSP)	800.877.7195	www.vsp.com
FSA	Workterra	888.327.2770	www.workterra.com email: custserv@WORKTERRAbenefits.com.
HSA	Sterling HSA	800.617.4729	www.sterlinghsa.com
EAP	MHN	800.242.6220	www.members.mhn.com To register, use company code: sbcountycourts
Human Resources		805.882.4739	www.sbcourts.org/gi/hr/benefits.asp email: HumanResources@sbcourts.org

CARECOUNCEL CAN ALSO HELP: **888.227.3334 6:30am – 5:00pm, M-F**

Key Terms

MEDICAL/GENERAL TERMS

Allowable Charge - The most that an in-network provider can charge you for an office visit or service.

Balance Billing - Non-network providers are allowed to charge you more than the plan's allowable charge. This is called Balance Billing.

Coinsurance - The cost share between you and the insurance company. Coinsurance is always a percentage totaling 100%. For example, if the plan pays 70%, you are responsible for paying the remaining 30% of the cost.

Copay - The fee you pay to a provider at the time of service.

Deductible - The amount you have to pay out-of-pocket for expenses before the insurance company will cover any benefit costs for the year (except for preventive care and other services where the deductible is waived).

Explanation of Benefits (EOB) - The statement you receive from the insurance carrier that explains how much the provider billed, how much the plan paid (if any) and how much you owe (if any). In general, you should not pay a bill from your provider until you have received and reviewed your EOB (except for copays).

Family Deductible - The maximum dollar amount any one family will pay out in individual deductibles in a year. IMPORTANT: If you enroll for family coverage on the 2022 plan, one or more family members will need to meet the individual deductible.

Individual Deductible - The dollar amount a member must pay each year before the plan will pay benefits for covered services. Important: If you enroll for family coverage on the 2022 plan, the individual deductible will need to be met by one or more family members.

In-Network - Services received from providers (doctors, hospitals, etc.) who are a part of your health plan's network. In-network services generally cost you less than out-of-network services.

Out-of-Network - Services received from providers (doctors, hospitals, etc.) who are not a part of your health plan's network. Out-of-network services generally cost you more than in-network services. With some plans, such as HMOs and EPOs, out-of-network services are not covered.

Out-of-Pocket - Healthcare costs you pay using your own money, whether from your bank account, credit card, Health Reimbursement Account (HRA), Health Savings Account (HSA) or Flexible Spending Account (FSA).

Out-of-Pocket Maximum – The most you would pay out-of-pocket for covered services in a year. Once you reach your out-of-pocket maximum, the plan covers 100% of eligible expenses.

Preventive Care – A routine exam, usually yearly, that may include a physical exam, immunizations and tests for certain health conditions.

PRESCRIPTION DRUG TERMS

Brand Name Drug - A drug sold under its trademarked name. A generic version of the drug may be available.

Generic Drug – A drug that has the same active ingredients as a brand name drug, but is sold under a different name. Generics only become available after the patent expires on a brand name drug. For example, Tylenol is a brand name pain reliever commonly sold under its generic name, Acetaminophen.

Dispense as Written (DAW) - A prescription that does not allow for substitution of an equivalent generic or similar brand drug.

Maintenance Medications - Medications taken on a regular basis for an ongoing condition such as high cholesterol, high blood pressure, asthma, etc. Oral contraceptives are also considered a maintenance medication.

Non-Preferred Brand Drug - A brand name drug for which alternatives are available from either the plan's preferred brand drug or generic drug list. There is generally a higher copayment for a non-preferred brand drug.

Preferred Brand Drug - A brand name drug that the plan has selected for its preferred drug list.

Preferred drugs are generally chosen based on a combination of clinical effectiveness and cost.

Specialty Pharmacy - Provides special drugs for complex conditions such as multiple sclerosis, cancer and HIV/AIDS.

Step Therapy - The practice of starting to treat a medical condition with the most cost effective and safest drug therapy and progressing to other more costly or risky therapy, only if necessary.

DENTAL TERMS

Basic Services - Generally include coverage for fillings and oral surgery.

Diagnostic and Preventive Services - Generally include routine cleanings, oral exams, x-rays, sealants and fluoride treatments. Most plans limit preventive exams and cleanings to two times a year.

Endodontics - Commonly known as root canal therapy.

Implants - An artificial tooth root that is surgically placed into your jaw to hold a replacement tooth or bridge. Many dental plans do not cover implants.

Major Services - Generally include restorative dental work such as crowns, bridges, dentures, inlays and onlays.

Orthodontia - Some dental plans offer Orthodontia services for children (and sometimes adults too) to treat alignment of the teeth. Orthodontia services are typically limited to a lifetime maximum.

Periodontics - Diagnosis and treatment of gum disease.

Pre-Treatment Estimate - An estimate of how much the plan will pay for treatment. A pre-treatment estimate is not a guarantee of payment.

Important Plan Notices and Documents

CURRENT HEALTH PLAN NOTICES

Notices must be provided to plan participants on an annual basis and are available on our benefits website **www.sbcourts.org/gi/hr/benefits.asp** for your reference. They include:

- Medicare Part D Notice
  Describes options to access prescription drug coverage for Medicare eligible individuals.
- Women's Health and Cancer Rights Act
  Describes benefits available to those that will or have undergone a mastectomy.
- HIPAA Notice of Special Enrollment Rights
  Describes when you can enroll yourself and/or dependents in health coverage outside of open enrollment.
- Notice of Grandfathered Plan Status
  Notifies you that a plan is grandfathered and does not include all Affordable Care Act (ACA) provisions.
- Children's Health Insurance Program Reauthorization Act (CHIPRA)
  Describes availability of premium assistance for Medicaid eligible dependents.
- Newborns' and Mothers' Health Protection Act
  Describes the right of mothers and newborns to hospital length of stay after childbirth.
- Notice of Availability of HIPPA Privacy Notice
  Notifies you of your right to receive a copy of the Insurance Carriers' HIPPA Privacy Notice.
- ACA 1557 Notice
  Notifies you that the Court complies with Federal civil rights laws and does not discriminate on basis of race, color, national origin, age, disability, or sex.

CURRENT PLAN DOCUMENTS

Important documents for our health plans can be found on our benefits website, **www.sbcourts.org/gi/hr/benefits.asp** and include:

Evidence of Coverage (EOCs)

An Evidence of Coverage, or EOC, is the legal document for describing benefits provided under the plan as well as plan rights and obligations to participants and beneficiaries. The following EOC plan descriptions is/are available:

- Blue Shield EPO Plan
- Blue Shield HDHP Plan

Summary of Benefits and Coverage (SBCs)

A Summary of Benefits and Coverage (SBC) is a document required by the Affordable Care Act (ACA) that presents benefit plan features in a standardized format. The following SBCs are available:

- Blue Shield EPO Plan
- Blue Shield HDHP Plan

Paper copies of these documents and notices are available if requested. If you would like a paper copy, please contact Human Resources at 805.882.4739.

Appendix

A. ELIGIBILITY RULES

Eligible Employees and Retirees
You are eligible to enroll in Court medical, dental, vision and applicable voluntary benefits plans if:

- you are a regular employee of the Court working at least 20 hours per week, or
- you are an extra-help employee working in a grant funded position working 20 or more hours per week and are expected to be employed for six or more months (medical, dental and vision only), or
- you are an extra-help employee who has worked an average of 30 hours per week in the measurement period (medical, dental and vision only; see below for terms),
- you are a qualified retiree who is currently receiving a retirement allowance from the Court.

The following terms and periods (as defined by the IRS) apply to extra-help employees:

- Upon Hire
  - Initial Measurement Period = 12 months from date of hire.
  - Administration Period = from the end of the initial measurement period to the end of the first calendar month beginning on or after the end of the initial measurement period.
  - Stability Period = 12 months beginning on the first day after the Administration Period.
- Ongoing Employees (an employee who has been employed by the Court for at least one complete standard measurement period.
  - Standard Measurement Period = October 15th of the previous year to October 14th of the current year.
  - Administration Period = October 15th through December 31st.
  - Stability Period = January 1st to December 31st.

Example: An extra help employee is hired on July 15 year 1.

- Initial Measurement period = July 15 year 1 to July 14 year 2.
- Administration period = July 14 year 2 to August 31 year 2.
- Stability period = September 1 year 2 to August 31 year 3.

This employee's hours will be measured again in year 2 using the same dates as the initial measurement period as they have not yet been employed through one full measurement period. In the third year they will move to the standard measurement period in October.

If they meet the eligibility requirements, coverage will continue from August 31 year 4 to December 31 year 4 at which time they will become an ongoing employee.

Eligible Dependents
Eligible employees and retirees who enroll in Court benefits plans may also enroll their eligible dependents in the Plan. Eligible dependents include:

- the employee's or retiree's lawful spouse as defined by applicable law, or legally registered domestic partner,
- the employee's or retiree's natural children, stepchildren, foster children, or adopted children of which the employee is the legal guardian who are under the age of 26, or your eligible

physically or mentally handicapped children who depend on you for support, regardless of age,

- The child of a covered domestic partner who satisfies the same conditions as listed above for natural children, stepchildren, foster children or adopted children, and in addition is not a "qualifying child" (as that term is defined in the Internal Revenue Code) of another individual.

- any child named in a qualified medical child support order for which an eligible employee or retiree is required to provide health coverage.

Eligible dependents do not include any person on active duty in the Armed Forces of the United States or any person covered as an employee or retiree under the Medical or Dental Plan. If both partners in a marriage or domestic partnership are eligible to be participants, then they may both be eligible for dependent benefits. Their children may be eligible to be enrolled as a dependent of both parents.

Documentary proof of dependent eligibility must be provided to Human Resources at the time of enrollment. Examples of types of documentation accepted may be requested from the Human Resources Department.

Waiver of Coverage
If an eligible employee chooses to waive health insurance coverage, they must do so by indicating their intention to waive coverage through the normal enrollment procedures. You must provide proof of alternative coverage to Human Resources in order to waive medical coverage.

Enrollment Requirements
New Hires: Eligible employees who want coverage under the Court's benefits plans must enroll through the normal enrollment procedures prior to their 30th day of employment.

Retirees: Retirees must enroll by completing the applicable enrollment form and submitting it when they complete and return the Court's Application for Retirement form.

Dependents: If an eligible employee or retiree wants their eligible dependents covered under the Court's benefits plans at the same time their initial coverage begins, the eligible dependents must be included in the initial enrollment process. If an eligible employee or retiree acquires eligible dependents after his initial enrollment, the dependent(s) must be enrolled within 31 days of the date they are acquired. A newborn dependent child is automatically covered from birth for 31 days. In order for coverage to be continued beyond the first 31 days, the enrollment process must be completed within 31 days following birth. 60 days are allowed for an event that is allowed under the Children's Health Insurance Program (CHIP) Reauthorization Act.

Late enrollment: If enrollment does not take place as provided above, the eligible employee or retiree may enroll himself and/or his eligible dependents in the Court's benefits plans only during the Court's annual open enrollment period except as provided below under "special enrollment."

Special enrollment: If an eligible employee or retiree does not enroll himself and/or eligible dependents in the Medical or Dental Plan because he or they were covered under another group health plan or had other health insurance coverage at the time enrollment in the Medical or Dental Plan was declined, the eligible employee or retiree may enroll himself and/or his eligible dependents in the Medical or Dental Plan if there is a qualifying status change.

Qualified Status Changes include:
- Change in legal marital status, including marriage, divorce, legal separation, annulment, and death of a spouse;
- Change in number of dependents, including birth, adoption, placement for adoption, or death of a dependent child;
- Change in employment status that affects benefit eligibility, including the start or termination of employment by you, your spouse, or your dependent child;

- Change in work schedule, including an increase or decrease in hours of employment by you, your spouse, or your dependent child, including a switch between part-time and full-time employment, that affects eligibility for benefits;
- Change in a child's dependent status, either newly satisfying the requirements for dependent child status or ceasing to satisfy them;
- Change in place of residence or worksite, including a change that affects the accessibility of network providers;
- Change in your health coverage or your spouse's coverage attributable to your spouse's employment;
- Change in an individual's eligibility for Medicare or Medicaid;
- A court order resulting from a divorce, legal separation, annulment, or change in legal custody (including a Qualified Medical Child Support Order) requiring coverage for your child;
- An event that is allowed under the Children's Health Insurance Program (CHIP) Reauthorization Act.

When Coverage Begins
If enrollment takes place during the Court's annual open enrollment period, coverage will begin on January 1. If enrollment is delayed because of other health coverage, coverage will begin on the date the other coverage is lost provided you enroll in the Court's plan within 31 days from the loss of coverage.

Following are the date coverage begins when enrollment takes place when a person is first entitled to enroll:

- New Hires:
    - Regular Employees: When enrollment requirements are met, coverage begins on the first day of the month after the employee's first day of employment.
    - Extra Help Employees: As determined by initial measurement period (page 1).
- New Retirees: When the enrollment requirements are met, coverage beings on the first day of the month following retirement or, if coverage has been extended under COBRA, on the date that coverage ends.
- Dependents: When enrollment requirements are met, coverage for eligible dependents begins on the date the eligible employee's or retiree's coverage begins or, if acquired after that date, the date the dependent becomes an eligible dependent.
- For marriage or domestic partnership, the effective date will be the first day of the first month following receipt of your request for enrollment;
- For birth, the effective date will be the date of birth;
- For a child placed for adoption, the effective date will be the date the Member, spouse, or Domestic Partner has the right to control the child's health care.

When Coverage Ends
Unless a special extension applies, coverage under the Court's benefits plans will end on the earliest of the following dates:

- for eligible employees and their eligible dependents only, the last day of the month during which the eligible employee's employment terminates or otherwise ceases to meet the requirements of an eligible employee;

- for retirees and their eligible dependents only, the last day of the month a retiree no longer qualifies for coverage because his retirement allowance from the Court ceases;

- for dependents only, on the last day of the month during which the dependent no longer qualifies as an eligible dependent;

- the date of complete termination of the Court's benefits plans or upon the effective date of an amendment to the Court's benefits plans which excludes the covered person from such status;

- the last day of the month following the date the Court receives written authorization from the eligible employee or retiree to terminate his health coverage. Important note to retirees: if dental coverage is voluntarily terminated by a retiree, it cannot be reinstated or added at a later date, even during an annual open enrollment period;

- the last day of the month for which any required self-payment was made for this coverage if the next self-payment is not paid when due.

Special Extensions
Physical or Mentally Handicapped Child: If a dependent child is physically or mentally handicapped on the date coverage would otherwise end because of age, the child's coverage will be continued for as long as the eligible employee or retiree is covered under the plan provided the handicap continues and the child continues to qualify as an eligible dependent in all aspects except age. The Court may require from time to time a physicians' statement certifying the physical or mental handicap.

Leave of Absence: Eligible employees may continue coverage during a leave of absence provided they continue twice monthly contributions as agreed upon with the Court and they comply with the applicable provisions of the Court's Leave of Absence Policy. If the Leave of Absence extends for greater than 18 months, the employee will be responsible for the full benefits' premium payment beginning in the 19th month of the leave of absence.

Employees entering the Armed Forces of the United States: If an eligible employee goes into active military service (including periodic reserve training) for any of the Armed Forces of the United States for up to 31 days, coverage may continue during the period of that leave, if such employee continues to pay his required contribution for coverage, if any. The Court will continue its contribution for coverage during such military leave. If an eligible employee goes into active military service for any of the Armed Forces of the United States for more than 31 days, coverage may continue for up to 18 months or the period of such military leave, whichever is shortest, if such employee pays the full cost of the coverage during the military leave.

Whether or not an eligible employee elects to continue coverage, coverage will be reinstated on the first day they return to active employment with the Court if they are released under honorable conditions and they return to work on whichever of the following dates is applicable:

- on the first full business day following completion of their military service for a leave of 30 days or less,

- within 14 days of completing their military service for a leave of 31 to 180 days,

- within 90 days of completing their military service for a leave of more than 180 days.

When coverage under the Medical & Dental Plan is reinstated, all provisions, limitations and exclusions of the Plan will apply to the extent that they would have applied if he had not taken military leave and his coverage had been continuous under the Plan. The foregoing, however, does not apply to coverage for any illness or injury caused or aggravated by military service, as determined by the Veterans Administration.

For further information see the individual plan Evidence of Coverage documents which are the controlling source of eligibility information.

B. ELIGIBILITY DOCUMENTATION

Dependent Type	Required Documentation	Resources to Obtain Documentation
Spouse (same or opposite gender)	Marriage Certificate **and** the portion of your most recent joint Federal or State Tax Return that lists filing status and includes the name(s) of the dependent spouse and/or children OR a current utility bill showing the spouse's name and employee's address.	• County office that issued original marriage certificate. • Personal tax records/IRS/CA Franchise Tax Board. • Utility companies. • **www.vitalchek.com**
Registered Domestic Partner	State of California, County or City issued Declaration/Certificate of Domestic partnership **and** the portion of your most recent joint State Tax Return that lists filing status and includes the name of the domestic partner OR a current utility bill showing the spouse's name and employee's address.	• County/City office that issued original certificate. • Personal tax records/CA Franchise Tax Board. • Utility companies.
Dependent child by birth, related to employee or dependent stepchild(ren)	Birth Certificate-must include parent's name, **and/or** copies of any court orders, divorce decrees or other legal documents relating to custody, health coverage or income tax exemptions.	• County office that issued original birth certificate. • Hospital in which child was born. • US Department of State (for children born outside of the US) • **www.vitalchek.com**
Dependent child by adoption	Final adoption papers, **and/or** copies of any court orders, divorce decrees or other legal documents relating to custody, health coverage or income tax exemptions.	• State agency that issued final adoption papers. • Adoption agency that issued placement papers.

Employee Benefits Brochure designed and developed by

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